again offering leadership. All Members have to do is follow the leadership of the gentleman from Georgia.

Mr. Chairman, I reserve the balance of my time.

Mr. ANDREWS. Mr. Chairman, I yield myself 2 minutes.

Mr. Speaker, a person goes to her primary care provider, and the primary care provider notices a lesion on the patient's skin. She says that she thinks that the patient ought to see a specialist to see what the lesion is. Her managed care plan says, no, we do not want you to do that because it does not fit our model of what ought to happen.

The patient does not see the specialist. It turns out the lesion is malignant and becomes metastatic cancer. The patient dies. The patient's estate sues the HMO under the laws of New Jersey or one of the other progressive States that has adopted patients' rights legislation.

Understand this: Under the Norwood amendment that will be coming forward in a few minutes, that claim is barred. Wiped out. No more. The Norwood amendment is a step backward. It does not intend to be, but it is, make no mistake about it.

Rights that the various States have given to consumers in the last few years are repealed. Whether it is by intent or sloppy drafting, they are repealed.

If Members believe in states' rights and the right of States to make decisions that affect their own communities, then Members should not federalize health care law. Then we should have not have one national decision that governs what ought to happen here. Members should reject the Norwood amendment, as the New Jersey Medical Society does for that reason, and Members should vote for the underlying base bill.

Mr. THOMAS. Mr. Chairman, I ask unanimous consent to yield the balance of my time to the gentlewoman from Connecticut (Mrs. JOHNSON) to control the time.

The CHAIRMAN. Is there objection to the request of the gentleman from California?

There was no objection.

Mrs. JOHNSON of Connecticut. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, I rise in strong support of the Norwood amendment, and I thank the gentleman from Georgia for his leadership. There has been no Member in this body who has been more dedicated to the issue of patients getting access to care and having the right to sue when their HMO denies them access to needed care. I commend the gentleman for that.

Mr. Chairman, I commend him particularly today for having the courage to help this House find a way to not only provide these rights to patients, these critical rights to access to specialty care, access to emergency room care, but also access to the right to sue, to provide these critical rights in a way that does two things. First, it restores power and control over our health care system to the doctors of America. That is what patients want. They want to have the right to the care their doctor recommends.

The Norwood amendment makes very clear that patients must exhaust the external panel review process so that the record shows doctors' review of doctors' decisions. In this era of exploding medical options, increasingly complex care, frankly we are going to need to have doctors reviewing doctors' recommendations to ensure that the patients' interests are best served.

Mr. Speaker, exhausting that panel review before patients get lawyers involved is critical. Otherwise we will do what the Dingell-Ganske bill does: We will simply take power from HMOs and give it to lawyers. This is not progress. This is not progress.

We want to return that power to doctors, and the Norwood amendment does that very clearly and very directly, and backs it up with a system that has two advantages. First of all, it shields the employer far more effectively than any other bill, by clarifying that patients can sue only the dedicated decisionmaker who must be bonded.

Therefore, employers can have confidence that they will not have to drop their plans out of fear of being sued. That is a tremendous strength of this Norwood amendment.

Second, the Norwood amendment is a simpler judicial process, a simpler legal system so that the costs do not explode. If the costs explode and the price of access to care and access to the right to sue is losing your health insurance, this is not progress.

Already premiums are rising rapidly. We see that: 15 to 20 percent this year when a 10–13% increase was expected and after double digit increases last year. In good conscience we must not add costs that do not benefit patients. We know from the history of malpractice insurance with doctors that until States controlled costs by adding tort reform or committees through which these proposed suits had to pass for approval, costs were extraordinary. Premiums leapt every year. And who paid? The employer and the employee. That is what is happening now. Employees are facing higher costs.

So the Norwood amendment not only guarantees these rights of access that are so critical to the quality of care and the right to sue, but it does it in a way that restores power to the doctors of our health care system. It does it through a legal structure that controls costs and protects employers who don't make medical decisions.

Mr. Speaker, those are my goals. The Norwood amendment fulfills them, and I commend the gentleman for his hard work.

Mr. Chairman, I am pleased to support the Norwood amendment. It puts in place strong patient protections in a responsible way.

Our goals are twofold: to guarantee patients access to the care they need and to guarantee patients right to sue if they are denied that care by their HMO. These patient rights are critical. Critical—but we must guarantee them without causing health care costs to skyrocket. Even without this legislation, premium costs are rising 15 to 20 percent a year and employees are carrying higher and higher copayments and deductibles. We must not, indeed we cannot, in good conscience further increase costs without knowing for certain that the benefit will be directly realized by patients.

I support the Norwood amendment because it guarantees the rights patients need to access specialists and emergency room care, to elect an OB/GYN or pediatrician as one's primary care physician, and other rights of access. It also provides the crucial right to sue one's HMO, but it would do this in a way that we know from experience with certainty will contain costs.

Under this amendment, patients will have the ability to hold plans accountable for poor medical decisions. But it is designed in a way that is straightforward and provides limits on liability, which allows employers to plan for their obligations and continue to offer health care coverage to their employees. In the end, this is the best result for patients.

The Ganske-Dingell liability construct is completely unworkable and will promote litigation years into the future that will only benefit trial lawyers, and not patients.

We must learn from history, when malpractice liability skyrocketed, it drove good doctors out of certain practices and sent premiums skyward. Only when states stepped in and limited liability did costs come under control and Americans no longer faced prohibitive increases in health care costs. Unless we limit liability in our Patients' Bill of Rights, we will set off a similar cycle of escalating costs.

Even before we get to the issue of the size of malpractice judgments, there is the problem of limiting other litigation to which health plans, providers, and employers are exposed. Under the Ganske-Dingell bill, there will be a virtual explosion of litigation activity, because the language of the bill is so complex and subject to so many different interpretations! In contrast, under the Norwood amendment, the rules are clearly written, the lines of liability are clearly spelled out, and most importantly the causes of action available to patients are very clearly defined.

On this last point about causes of action, I would like to point out that under the Ganske-Dingell bill the availability of a cause of action depends on the interaction of state law and the 19 pages of requirements outlined in the bill. That alone will result in years of litigation just to determine jurisdiction and the elements of a cause of action. And that's before we even get to the patient's case.

I want to make one other point about simplicity versus complexity. Under the Ganske-Dingell approach, there are two groups that can be held liable for plan decisions—the ''designated decisionmaker'' and a ''direct participant'' in the decision. There are two separate processes for holding these different actors liable, and they are inconsistent. This alone will foster litigation, because plaintiffs will name everyone possible and the courts will have to sort out the liability.

In contrast, the Norwood amendment requires the naming of a designated decisionmaker and requires that the decisionmaker be bonded so that a plaintiff is assured of being able to recover damages.